CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

First _____ **MI** ____ **Last** _____

Address _____

City _____**State** _____ **Zip** _____

Home (_____) _____ **Cell** (_____) _____

In Case Of Emergency, Contact _____

Text Reminders? Y____ N_____ Cell Phone Provider? _____

When: 1 hour, 2 hours, 4 hours or 1 day before appointment? _____

E-mail _____

Birthdate _____ **Age**_____ **Sex** ❑ M ❑ F

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Preferred Language: ❑ English❑ Spanish ❑ Other_____

Race (circle): American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Pacific Islander, White, Multi-racial, **Other** _____

Ethnicity: Not Hispanic or Latino, Hispanic or Latino, Decline to Specify

Smoke: (Circle) Current everyday / Current someday / Former smoker OR Never smoked

Whom may we thank for **referring you?** _____

EMPLOYMENT/SCHOOL INFORMATION

Occupation _____

Patient Employer/School _____

Employer/School Address _____

City_____ St_____ Zip _____

Employer/School Phone (_____) _____

PATIENT INFORMATION

Primary Care Physician _____

Facility ❑ Bellin ❑ Prevea ❑ Aurora ❑ Other _____

Doctor(s) who have treated your condition

_____

Facility❑ Bellin ❑ Prevea ❑ Aurora ❑ Other _____

Height ____ ft ____ in **Weight**_____ lbs **Blood Pressure**_____

FAMILY HISTORY

What diseases run in your parents, siblings, and children?

Relationship	**Disease**
_____	_____
_____	_____
_____	_____

INJURY INFORMATION

Is this condition due to an accident? ❑ Yes ❑ No

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Gym ❑ other

To whom have made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker's Comp. ❑ other

Attorney Name _____

ALLERGIES

_____

_____

_____

_____

_____

MEDICATIONS

_____

_____

_____

_____

_____

_____

_____

PATIENT CONDITION

Reason(s) for Visit 1.)_____ 2.) _____ 3.)_____

When did your symptoms appear? _____ **How?** _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Please answer the following four questions about the severity of pain on a scale from 1 (least) to 10 (most) –

What is your pain **RIGHT NOW?** _____ What is your TYPICAL or **AVERAGE pain?** _____

What is your pain level **AT IT'S BEST?** _____ What is your pain level **AT ITS WORST?** _____

Type of Pain: ❑ Sharp ❑Throbbing ❑Numbness ❑Aching ❑Shooting ❑Burning ❑Tingling ❑ Stiffness

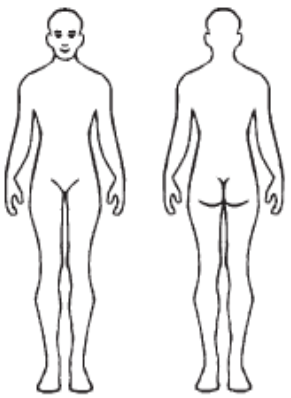
How often do you have this pain? _____ ❑ Constant ❑ Comes and Goes

Does it interfere with your? ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform: ❑ sitting ❑ standing ❑ walking ❑ bending ❑ lying

Are you pregnant? ❑ Yes ❑ No **Due Date** _____

Mark an X on the picture where you have pain, numbness, or tingling.



HEALTH HISTORY

What treatment(s) have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy

❑ Chiropractic Services ❑ None ❑ Other _____

Date of Last: Physical Exam _____ Spinal X-Ray _____

Spinal Exam _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Alcoholism	❑ Yes ❑ No	Chicken Pox	❑ Yes ❑ No	Prosthesis	❑ Yes ❑ No		
Allergy Shots	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Migraines	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Anorexia	❑ Yes ❑ No	Fractures	❑ Yes ❑ No	Miscarriage	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Appendicitis	❑ Yes ❑ No	Gout	❑ Yes ❑ No	Multiple Sclerosis	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Tumors/Growths	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No	Other	
Bleeding Disorder	❑ Yes ❑ No	Hernia	❑ Yes ❑ No	Parkinson's Disease	❑ Yes ❑ No	_____	
Breast Lump	❑ Yes ❑ No	Herniated Disc	❑ Yes ❑ No	Pinched Nerve	❑ Yes ❑ No	_____	
Cancer	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Prostate Problem	❑ Yes ❑ No	_____	

REVIEW OF SYSTEMS

Check all that you have had <u>in the last 3 months</u>:

❑ Fevers or chills
❑ <u>Unexpected</u> weight loss of more than 10 pounds
❑ Difficulty Sleeping
If yes, how long does it take to fall asleep?_____
How many times a night do you awaken?_____
❑ Long breathing pauses while sleeping
❑ Loss of vision or double vision
❑ Difficulty swallowing, smelling, or hearing
❑ Swelling in feet or ankles
❑ Chest pain or tightness
❑ Shortness of breath
❑ Coughing or coughing up blood
❑ Stomach or belly pain
❑ Nausea and/or vomiting
❑ Problems with bowel movements
❑ Constipation
❑ Diarrhea
❑ Accidental bowel movements
❑ Bloody or black stools
❑ Problems with urination
❑ Accidental urination
❑ Inability to urinate
❑ Urge to urinate more frequently
❑ Burning, foul smelling, cloudy, or bloody urine
❑ Problems with sexual function
❑ Leg cramps when walking or at night
❑ Skin rashes
❑ Depression
❑ Frequent headaches
❑ Unconsciousness
❑ Difficulty talking
❑ Poor coordination
❑ Difficulty walking
❑ Loss of balance/falling
❑ Numbness/tingling of arms or hands
❑ Weakness in arms or hands
❑ Weakness in thighs, legs, or feet

EXERCISE

❑ None
❑ Moderate
❑ Daily
❑ Heavy

WORK ACTIVITY

❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

HABITS

❑ Alcohol Drinks/Week _____
❑ Coffee/Caffeine Cups/Day _____

SOCIAL HISTORY

Highest Education Completed_____
Children ❑ Yes ❑ No
Names & Age _____
_____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACKNOWLEDGEMENT AND CONSENT

The federal laws that protect your protected health information ("HIPAA") do not provide you with complete privacy. HIPAA allows your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operational); and
- In limited and unusual circumstances related to public health matters and research.

Our Privacy Policy. We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, we have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

Your Right to Limit Uses or Disclosures. You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place a restrictions on the use of disclosure of your health information, you must inform us in writing.

Your Right to Authorize Us to Disclose Your Protected Health Information. You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

Your Right to Revoke Any Limitation, Authorization, or Consent. You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent to revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

I ACKNOWLEDGE receipt of the PRIVACY POLICY and CONSENT to my personal health information being used in the manner described above. I am also acknowledging that I have received a copy of this consent.

_____	_____
Patient Name Printed	**Date**
_____	_____
Patient (or Personal Representative) Signature	**Authorized Provider Representative**
_____	_____
Personal Representative's Name Printed	**Personal Representative's Authority**

I am acknowledging that I have received a copy of the PRIVACY POLICY and this consent but DECLINE to give my chiropractor and members of the practice staff consent to use my protected health information for any purpose other than treatment and those required by federal law.

_____	_____
Patient Name Printed	Date
_____	_____
Patient (or Personal Representative) Signature	Personal Representative's Authority